Title: Medicaid Coverage for the Lowest Income Populations (Benchmark Benefits)
Section: 2001
State Option

Overview: Beginning January 1, 2014, Section 2001 of the Patient Protection and Affordable Care Act (ACA) expands Medicaid eligibility to all individuals under age 65 with incomes up to 133% of the federal poverty level (FPL) based on modified adjusted gross income. These "new eligible's" are entitled to benchmark or benchmark-equivalent coverage rather than full Medicaid benefits.

A benchmark benefits package, as set forth in the Deficit Reduction Act of 2005 (DRA), allows states the option to provide certain groups of Medicaid enrollees with an alternative benefit package. It may be based on one of three commercial insurance products or a benefit package approved by the Secretary of Health and Human Services. The ACA added a requirement that benchmark benefits provide "essential health benefits," discussed below. The major federal rules governing benchmark coverage include the following:

1. Benchmark and benchmark-equivalent coverage must include essential health benefits, which include the following categories of services:

    - Ambulatory patient services;
    - Emergency services;
    - Hospitalization;
    - Maternity and newborn care;
    - Mental health and substance use disorder services, including behavioral health treatment;
    - Prescription drugs;
    - Rehabilitative and habilitative services and devices;
    - Laboratory services;
    - Preventive and wellness services and chronic disease management; and
    - Pediatric services, including oral and vision care.
    - Early Periodic Screening and Developmental Services (EPSDT) *was added with CHIPRA (PL-111-3)*

    The Secretary of Health and Human Services will be issuing regulations to further define what constitutes essential health benefits.

"The state agency must provide benchmark assistance to the newly eligible beneficiaries even if the state plan did not previously include that optional benefit (SSA Sec. 1902(k)(1), added by the Affordable Care Act Sec. 2001(a)(2)(A)). Federal Matching funds are not available for traditional Medicaid benefits for this group (SSA Sec. 1903.(i)(26), added by Affordable Care Act Sec. 2001(a)(2)(B)))." (2010, Wolters Kluwer)

2. Coverage must be equal to the coverage provided in one of three benchmarks, equivalent in actuarial value to one of three benchmarks, or a package approved by the Secretary (i.e., benchmark-equivalent). The three benchmark plans are:

   I. The standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employees Health Benefits Plan (FEHBP);
   II. A health plan offered to State employees; or
   III. A managed care plan with the largest commercial, non-Medicaid enrollment in the State.

   States also can provide additional benefits on top of what is required in a benchmark-equivalent plan as long as the services are included in the benchmark plan or could be covered under "regular" state plan Medicaid. Coordination between the newly eligible benefit plan and current Medicaid plan will be essential to minimize confusion and reduce the financial implications.

3. Benchmark and benchmark-equivalent coverage must meet other Medicaid requirements, including requirements to cover transportation services, family planning services, and care provided by rural health clinics and federally qualified health centers. Also, such coverage, if it is provided through managed care entities, must comply with Medicaid managed care requirements. In addition, states must secure public input prior to filing a proposal with HHS to use benchmark or benchmark-equivalent coverage.

The exclusion of long-term care (i.e., nursing home coverage) may be the most significant difference between a benchmark benefit and traditional Medicaid. The new eligibles may have access to habilitative services that are not available to the current state plan Medicaid recipients.

Targeted Populations: "Newly-eligible" Medicaid beneficiaries.

- Individuals with household incomes up to 133 percent of the federal poverty level,
- Under the age of 65

- Are not pregnant
- Not entitled to or enrolled in benefits under Medicare Part A
- Not enrolled under Medicare Part B
- Not eligible for Medicaid under any other eligibility category.

Excluded Populations: A number of groups of people would be exempt from mandatory enrollment in benchmark coverage and must be offered the traditional, full Medicaid benefit package. These groups include: people with disabilities; dual eligibles (i.e., people enrolled in Medicare and Medicaid); medically frail; certain low-income parents; and other special groups of people (e.g., pregnant women, women who qualify for Medicaid because of breast or cervical cancer, children in foster care or receiving adoption assistance).

Nevada Check Up: The current eligibility guidelines for Nevada Check Up (NCU) cover children in families with incomes below the proposed Medicaid eligibility level of 133% FPL. It is likely that some of the current NCU eligibles will become Medicaid eligible, as will some of the parents of these children.

Fiscal Implications: While the federal government will cover 100 percent of the cost of coverage for the newly-eligible Medicaid beneficiaries for the first three years, the State's share of the cost will eventually reach 10 percent. At an average cost of approximately $2,800 per beneficiary, the additional cost to the State may exceed $28 million when the State becomes responsible for 10 percent of the cost of the benefits provided to these newly-eligible beneficiaries.

Applicability to Nevada: The expansion of Medicaid to individuals with income up to 133 percent of the federal poverty level will add upwards of 100,000 people to Nevada's Medicaid program. The ACA provides some flexibility to states to establish a benefit package for newly-eligible individuals.

The State's Medicaid program will conduct an assessment of the benefit packages that may be offered to these newly-eligible individuals. This includes an evaluation of the benefits provided to federal employees, State workers, and those offered by Nevada's commercial managed care plans. Our analysis will compare those benefits to the benefits provided to current Medicaid beneficiaries to identify the differences, quantify the potential impact to beneficiaries and develop an estimate of the potential affect on the cost of coverage.